WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

Traumatic Brain Injury Waiver Program
Case Management Initial Contact Log

Applicant:

Last Name_____ First Name_____ MI_____

Date Case Manager received notification from APS Healthcare of applicant selection

_____

Date of Initial Contact_____ (Circle one only) Face to face/Telephone (Initial contact must occur within five (5) business days of notification from APS Healthcare, Inc.).

Case Manager Signature_____Date_____

Notice of Medical Eligibility

The Case Manager must submit a TBI DHS-2 form (White) to the county DHHR office within sixty (60) calendar days from the date the case management agency or the applicant receives the notification of applicant medical eligibility.

Date TBI white DHS-2 form submitted to applicant's county DHHR _____

Date APS Healthcare, Inc. was notified _____

Once an applicant has been found medically and financially eligible, the Case Manager must request Program Enrollment from APS Healthcare, Inc. by completing an Enrollment Request form.

Date Program Enrollment Request form was submitted to APS Healthcare, Inc._____

Case Manager Signature_____Date_____

Comments:

_____

_____

Participant:

Program Enrollment Date_____

(Person-Centered Assessment must be completed within 7 calendar days of Program Enrollment).

Date of Case Manager's Scheduled Home Visit for Person-Centered Assessment_____

(Initial Service Plan Meeting must be scheduled and held within 7 calendar days of the Person-Centered Assessment. It may be held at the same time or sooner if agreed upon by the case manager and person receiving services.)

Date of the Initial Service Plan Meeting_____

Interim Service Plan* Implemented? (Only for program participant who require immediate services.) □ Yes □ No (**An Interim Service Plan is only available to people who have chosen to use the Traditional Service Model.

Date Service Plan, Assessment, and Request for Service Authorization form (which identifies the person's budget) were sent to APS Healthcare. _____ (must be within five (5) calendar days of the Service Plan meeting.)

Case Manager Signature_____ Date_____

Comments: _____
_____

Seven (7) Day Contact:

Date direct care services began _____ (within five business days of authorization)

Date of Case Manager's follow up contact _____
(Circle one only) Face to face/Telephone
(Must be completed within 7 calendar days of date direct care services began).

Comments_____
_____

Case Manager Signature _____ Date _____

10/2015